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	495390	A. BUILDING _____ B. WING _____	C 10/20/2016

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BIRMINGHAM GREEN	8605 CENTREVILLE ROAD MANASSAS, VA 20110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/18/16 through 10/20/16. Two complaints were investigated. Corrections are required for compliance with the following Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 177 at the time of the survey. The survey sample consisted of 28 resident reviews, 24 current resident reviews (Residents #1 through #24) and 4 closed record review (Resident #25 through #28).	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility document review the facility staff failed to implement assistance devices and supervision to prevent avoidable falls with injuries for 2 of 28 residents in the survey sample, Resident #10 and #14. 1. The facility identified Resident #10 was a fall	F 323	Past noncompliance: no plan of correction required.	11/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/12/2016

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risk. The facility developed a plan of care to prevent falls which included the use of two staff for transfers. The resident was transferred on 2/10/16 by one staff instead of two. During the transfer the resident's knee "gave out" and the resident was lowered to the floor. Furthermore, the staff failed to use a gait belt, an assistance device. As a result of the fall the resident sustained a fracture to the right ankle resulting in harm.
2. For Resident #14, the facility staff failed to ensure necessary supervision/assistance and fall prevention interventions were implemented to reduce and/or prevent falls for a known high fall risk resident. The resident sustained a right hip fracture 11/3/15 and a left hip fracture 11/17/16 related to falls.

The findings included:

1. Resident #10 was originally admitted to the facility on 11/1/06 and readmitted on 12/22/14. Diagnoses included chronic obstructive pulmonary disease, age related osteoporosis (OP-loss of bone mass predisposing to fractures), ataxic gait (unsteady, abnormal uncoordinated movement).

The quarterly MDS (Minimum Data Set-a resident assessment and care screening) with an assessment reference date of 1/13/16 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was assessed as requiring two staff for transfers (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position). The resident was not steady, only able to stabilize with staff assistance when

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moving from seated to standing position...surface-to-surface transfers. Under Section J. Health Conditions had one fall since admission/entry or reentry or the prior assessment. The resident was 63 inches tall and weighed 174 pounds.

The Fall Risk Assessment Form dated 1/20/16 assessed the resident's score as a 13. A score of 10 or more indicates a High Risk for falls.

The plan of care with a review date of 1/27/16 identified the resident was at risk for falls related to impaired mobility, OA (arthritis), OP, and restless leg syndrome. The goal was listed as the resident's safety will be maintained as evidenced by having no significant injuries from falls. One of the approaches listed to maintain/achieve the goal was that the resident required 2 person assist with transfers.

Review of the clinical nurses notes evidenced an entry dated 2/10/16 at 10:55 a.m. The nurse documented she was called to the resident's room by a certified nurse aide (CNA). The resident was observed on the floor. The CNA reported she was transferring the resident out of bed to the wheelchair, the resident complained of right knee pain and the leg started to slide. The resident was "slid to the floor". The nurse assessed the resident. The resident complained of right ankle pain when touched. The physician was called, and ordered an x-ray of the right knee and right ankle, and Norco 5-325 mg (milligram) one tablet by mouth every six hours as needed for pain (Norco is a controlled drug). The responsible party was called and notified.

The x-ray report exam date 2/10/16 impression

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was an acute right ankle fracture.

The physician was notified of the x-ray result. New orders to ace wrap the right ankle to stabilize the right foot/ankle, non-weight bearing until seen by the podiatrist on 2/11/16.

The resident was seen by the podiatrist on 2/12/16. A Cam boot was placed on the resident's right foot that was to be kept on at all times and orders to maintain non-weight bearing to the right leg.

Cam is an acronym meaning controlled ankle motion. Its primary purpose is to prevent or limit ankle and foot movement.

On 10/19/16 at 3:20 p.m., the resident was observed sitting up in a wheelchair at the beside watching t.v. and drinking a cup of coffee. The resident was asked about the fall with fracture. She stated she slid off the side of the bed during a transfer. She stated, "she (CNA) should have had 2 people...my foot got caught between the spokes of the wheelchair".

The fall incident report and investigation dated 2/10/16 was reviewed. Under contributing factors the "No" box was checked for Gait belt in use?

The Post Incident Staff Interview dated 2/10/16 was completed by the involved CNA. One of the interview questions was, What do you think will help prevent incident from occurring? The answer was: "2 person assist transfer".

The CNA is no longer employed at the facility.

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An interview with the Administrator and the Acting Director of Nursing (ADON) was conducted on 10/20/16 at 11:00 a.m. They were asked by this inspector, "Did the CNA use a Gait belt while transferring the resident?" The Administrator answered, "No". When asked, "Should the CNA have used a Gait belt?" The administrator answered, "Yes". When asked, "Should the CNA have had a second person to assist with the transfer?" The Administrator stated, "Yes". The Administrator stated she understood that the CNA was not aware that the resident required a two person assist, although the CNA had been assigned to care for the resident previously. The Administrator stated as a result of this fall, all staff were inserviced on the use of Gait belts and appropriate number of staff for transfers. The Staff Development Coordinator provided this inservice to educate all CNAs on the importance of always having their Gait belt on them as part of their uniform. Gait belts are to be used for all 1-2 person assist, excluding Hoyer (a mechanical lift) transfer. The Administrator stated a Care Card is stored inside each residents wardrobe closet. The care card contains information for staff to use that includes how the resident is to be transferred. Resident #10's care card was correct for a two person transfer at the time of the fall.

The purpose of a Gait Belt is to provide safety and protection from possible injury during transfer and ambulation.
www.vdh.virginia.gov/mrc/wthrc/document/pdf/Transfer-Using-Gait-Belt.

The facility staff failed to implement approaches per Resident #10's plan of care to ensure resident safety due to fall risk; as a result the resident sustained a major injury.

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The instituted a plan of correction for falls as follows:
1. all licensed staff educated on knowing and following each resident's plan of care for safe transfers. Completion date 2/16/16
2. All nursing and CNA report sheets will be updated on (name of unit) to include how each resident is care planned for transfers. Completion date 2/12/16
3. Nurses on (name of Unit) will be reeducated on the importance of knowing each each resident's plan of care and communicating changes immediately to the direct care staff. Completion date 2/15/16
4. Nurses on all neighborhoods will be reeducated on the importance of knowing each resident's plan of care and communicating changes immediately to the direct care staff. Completion date 2/26/16
5. All nursing and CNA report sheets will be updated on (name of units) to include how each resident is care planned for transfers. Completion date 2/26/16
6. All CNAs will be reeducated on the importance of always having their gait belts on them as part of their uniform. gait belts are to be used for all 1-2 person assist, excluding Hoyer transfers. Completion date 2/26/16
7. Audit 100% of the care cards will be conducted for accuracy to the care plan. Variances will be investigated and corrective action will be taken as appropriate. Completion date March 2016

This incident is found to be Past Non-Compliance, as the facility identified the non-compliant practice and corrected it prior to survey.

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2. Resident #14 was originally admitted to the facility 5/29/14 and readmitted 11/21/15 after an acute hospitalization. The current diagnoses included; Alzheimer's dementia, hypertension, anemia, age-related osteoporosis and status post bilateral hip fractures.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/11/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #14 cognitive abilities for daily decision making were severely impaired. Resident #14 was coded as not having mood or behavior problems, requiring extensive assistance of 1 with walking in the room and eating, extensive assistance of 2 with bed mobility, transfers, walking in the corridor, locomotion on the unit, dressing, toileting, personal hygiene and total care of 1 with bathing. The resident was coded as frequently incontinent of bowels and bladder. Resident #14 was coded for walking with a walker and stabilizing only with staff assistance. Unsteadiness was coded when the resident was moving from sitting to standing, turning around while walking, moving on an off the toilet and transfers/bed to chair and wheel chair.

A history and physical from a local hospital dated 11/17/15 read; Resident #14 had multiple falls recently. The first fall on 11/3/15 resulted in a right hip fracture. The resident had another fall 11/4/15 after getting tripped on a wheel chair trying to get up from the wheel chair and hit her head. Today 11/17/15 the resident woke up in the middle of the night and tried to walk and had another fall and

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was sent to the emergency room. This time the resident was with a fracture of the left hip. The Plan; hospitalize the resident, plan for left hip surgery in the morning and pin the right hip at the time of surgery to prevent any concerns for displacement of the right hip fracture going forward.

Review of the clinical record and facility Incident Accident Forms evidenced the resident had the following falls:
11/3/15 at 4:55 p.m.- Resident was in the dining room, stood up to go to the bathroom, tripped over feet and fell to the floor. The resident sustained a hairline non-displaced fracture of the right femoral neck (hip). The physician's treatment plan was to watch the fracture and not operate at that time. The facility's investigation stated there were 2 certified nursing assistants (CNA) present at the time of the fall but no interventions were initiated when the resident stood. One of the 2 CNAs was on 1:1 duty with another resident. Intervention: use of wheel chair.

11/4/15 at 4:20 p.m. - Resident observed on the dining room floor when the Unit Manager walked into the dining area. The resident had been in a wheel chair. There was no facility investigation of this fall. Interventions instituted included 1-2 persons to aid with transfers and 1:1. During an interview with the Unit Manager on 10/20/16 at approximately 11:30 a.m., the Unit Manager stated an investigation was not conducted for this fall. The resident's care plan did not include 1:1 interventions.

11/16/15 at 10:50 p.m. - Resident observed on the floor in a sitting position with the back towards the bathroom door. Had previously been in bed.

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The resident complained of left hip pain. The resident sustained a left intertrochanteric (hip fracture). The facility's investigation revealed the resident had gotten out of bed toileted herself and was returning to bed when she fell. The staff was alerted by the roommate. Interventions initiated included moving resident to a room closer to the nurses' station and away from the resident awaking her during the night. Bed pad alarm and non-skid shoes when in bed.

11/18/15 - The resident had open reduction and internal fixation of the left hip fracture and percutaneous pinning of the right hip fracture simultaneously.

A bed or chair alarm is a personal alarm that allows a caregiver to monitor the activity of a resident when in bed or in a chair and alert the staff of unassisted movements. A tab alarm has a string which attaches to the resident's clothing and another item such as a chair. When the resident stretches the string by rising the action removes the tab from the alarm box and it sounds. The pad alarm has a sensor which operates through detection of a reduction of pressure when the resident rises or moves off the pad.

The Unit had one large room used for dining and activities. The residents were observed seated at a long table in this room most of the day.

An interview was conducted with Resident #14's Responsible Party by phone on 10/20/16 at 11:50 p.m. The Responsible Party stated she is worried about the number of falls the resident has experienced and she desires something be done about it. The Responsible Party stated the

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resident always enjoyed walking and believes she is aware of toileting needs but she wonders if the resident's safety can be accomplished with the current staff.

The clinical record review revealed Resident #14's Fall Risk Assessments. The assessment form stated a score of 10 or more indicates a high risk for falls. The 9/7/15 assessment score was 6, 11/4/15 score was 13, 11/16/15 score was 15, 11/23/15 score was 15, 12/1/15 score was 20, 12/11/15 score was 19, 3/16/16 score was 21, 5/21/16 score was 21, 6/7/16 score was 21, 8/30/16 score was 21, 9/1/16 score was 23 and the 9/25/16 score was 21.

The care plan dated 6/17/15 and was in use at the time of the 11/3/15 fall, the problem read; At risk for injury from falls related to impaired mobility, impaired cognition with poor safety awareness, CLBP (sic), compression fracture lumbar 2, vision impaired, and use of daily antipsychotic medication. The goal read; Resident's safety will be maintained as evidenced by having no significant injuries from falls this review. The approaches were; Be aware resident is receiving antipsychotic, diuretic and two blood pressure medications daily - Monitor for any potential interactions or side effects from medications. Evaluate resident's room for easily modified hazards (poor lighting, poorly arranged furniture, etc., which might contribute to falls) Keep bed in the lowest locked position. Keep frequently used items within reach. Keep pathways free of obstacles/clutter/spills. Make sure resident has her eyeglasses on during waking hours. Monitor for complaints of pain both verbal and non verbal, medicate with as needed medications and alert the physician if a change

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may be indicated. Non-skid shoes when out of bed, or appropriate of footwear when up out of bed. Place call bell in position - Be aware cognitive status prohibits use of the call bell. Provide frequent checks when in room in bed. physical therapy/occupational therapy as needed to develop a plan and maintain/increase mobility. Resident needs limited hand held assistance with bed mobility, transfers and ambulation. Review fall risk assessment scores quarterly and adjust plan of care as needed.

Care plan approaches added 11/30/15 were: bed and wheel chair alarm in place to alert staff of unassisted transfer attempts. Bed pad alarm in place to alert staff of unassisted transfer attempts. Non-skid socks to be on when in bed. Encourage rest periods. Orthopedic consult with follow-ups per orders - see treatment administration records. Physical Therapy/Occupational Therapy to develop a plan to maintain/increase safe mobility. Extensive assistance with bed mobility, transfers and ambulation. Also use of wheel chair for longer distances.

Resident #14 was observed 10/18/16 at approximately 1:15 p.m., seated in the dining/activity area at the table with a tab alarm attached to self and the straight back chair.

Resident #14 was observed 10/19/16 at approximately 9:30 a.m., seated in the dining/activity area at the table with a tab alarm attached to self and the straight back chair.

Resident #14 was observed 10/20/16 at approximately 1:30 p.m., seated in the

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dining/activity area at the table with a tab alarm attached to self and the straight back chair.

The resident had Physician's orders dated 11/24/16 for Bed in the lowest position while resident is in bed, check placement every shift. Bed pad alarm in place while Resident is in bed. Tab alarm on at all times in bed and chair to alert staff of unassisted transfers. Monitor placement of fall mats bedside bed while resident is in bed.

The facility's undated policy titled "Fall Prevention and Management Program" read; #1. All residents will have a Fall Risk Assessment completed upon admission, readmission, quarterly or a significant change. The results of the fall risk assessment will be communicated to the interdisciplinary team. #7. The fall investigation form will be utilized in reviewing and revising the resident's care plan to minimize the recurrence of falls or injury. #11 The interdisciplinary team will evaluate the need for preventative/corrective measures and will make recommendations to reduce risk of reoccurrence. #12. The Nurse Manager will assure that the recommended measures are put into place and the care plan is updated to reflect changes.

The above findings were shared with the Administrator, Assistant Administrator and Director of Nursing during the pre-exit meeting on 10/20/16 at approximately 2:20 p.m. The facility staff present was asked if the residents are left unsupervised in the dining/activity room frequently. The Assistant Administrator stated they have now instituted assigning a staff member (CNAs and/or activity) to monitor and remain in the dining/activity room from 7:00 a.m. to 7: 00 p.m. to ensure the residents are

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F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.35(i) The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review the facility staff failed to store food, maintain food temperatures and implement appropriate hand washing to prevent the outbreak of foodborne illness. The findings included: An initial kitchen inspection was conducted on 10/18/16 at 3:00 p.m. Accompanying the two inspectors was the Food Service Director (FSD). The following non-compliance issues were found: 1. One of two milk box reach in refrigerator temperatures was 46 degrees. Several crates of single serve milk cartons were stored inside. 2. Stored inside the walk in refrigerator was a large metal pan filled with chicken cutlets used for salad. This product was not dated. A large metal pan of shredded cheese and a plastic container of grape tomatoes were dated to be used by	F 371	The submission of the Plan of Correction does not constitute agreement on the part of Birmingham Green that the deficiencies cited within the report represent deficient practices on the part of Birmingham Green. This plan represents the facility's ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements. The Plan of Correction shall serve as our allegation of compliance. 1)Milk boxes temperature There were no residents affected. All residents may be at risk from this deficient practice. Facility Services inspected the milk box	11/15/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 10/17/16. 3. A large plastic container with super cereal was stored next to the cook's area and was not dated. 4. An observation of the lunch meal plating was conducted on 10/19/16 from 11:05 a.m. through 11:40 a.m. Two food service employees were observed on five different occasions to wash their hands between changing tasks and re-entering the kitchen for a duration of less than 20 seconds. The duration of hand washing observations were 8 seconds, 6 seconds, and three for 2 seconds. The Food Service Director was interviewed on 10/19/16 at 2:55 p.m. The above findings was shared. The FSD stated the kitchen staff had recently attended an inservice on hand washing. A copy of the inservice on Hand Washing dated May 24-26, 2016 was provided for review. The inservice read, in part: 5. Use good Hand Hygiene: ... Soap and water (20 seconds)... The facility policy titled "Preventing Foodborne Illness-Employees and Sanitary Practices" dated December 2008 read, in part: Food Service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. 6. Employees must wash their hands: c. Whenever entering or re-entering the kitchen. g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks... The facility policy titled "Food Receiving and Storage" dated December 2008 read, in part: Foods shall be received and stored in a manner	F 371	and made necessary adjustments to create better air flow restoring milk box back to proper temperature of 40F on 10/20/16. Refrigerator/Freezer temperatures will be taken and documented three times per day. Temperatures will be taken by the cook or designee. Food Service Department re-educated staff on proper temperature ranges for Refrigerators / freezers, and new times for taking/recording refrigerator/freezer temperatures on 11/4/16 Manager or designee will audit refrigerator / freezer temperatures 3 times per week for 6 months. Summary of findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QA Committee for review and recommendations. Compliance Date: 11/15/16 2)Labeling and dating There were no residents affected. All residents may be at risk from this deficient practice. Food Service Department re-educated staff on procedure for proper labeling and dating (including any container used for food storage from an original container)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495390	A. BUILDING _____ B. WING _____	C 10/20/2016

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F 371	Continued From page 14 that complies with safe food handling practices. 6. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date) in accordance with Federal, State or Local Guideline.	F 371	on 10/19/16 and 10/20/16. Food Service Department added daily checking of labeling and dating to all cook and prep cook daily assignment sheets on 11/1/16. Manager or designee will audit the kitchen for proper label and dating three times per week for 6 months. Summary of findings will be reviewed through the monthly Clinical Operations Report (COR) process and submitted to quarterly QA Committee for review and recommendations. Compliance Date: 11/15/16 3)Hand washing There were no residents affected. All residents may be at risk from this deficient practice. Staff were re-educated on proper hand washing on 10/19/16 and 10/20/16. Food Service Department will include hand washing as a monthly in-service. Food Service Manager or designee will conduct random observation of hand washing to ensure compliance three times per week for 6 months. Summary of findings will be reviewed through the monthly Clinical Operations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 15	F 371	Report (COR) process and submitted to quarterly QA Committee for review and recommendations. Compliance Date: 11/15/16	